

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12532

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jordan's Canning House</u>				d. STREET ADDRESS <u>Jordan's Canning House</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Augustus</u> Middle <u>Berding</u> Last <u>G</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Augustus Berding</u>			14. MOTHER'S MAIDEN NAME <u>Wilhelmina Knopf</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-1534</u>		17. INFORMANT <u>Walter and Harry Dowd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-23-58</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 25, 1958 Western Ave</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Md</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hawk</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PRIMEVAL RECORD

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

CERTIFICATE OF DEATH

12532

12531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY in 1b <i>2 1/2 hrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. STREET ADDRESS <i>10000 Route # 3, Box 8FA</i>			
3. NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>MARIE</i> Last <i>Benedict</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>4</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-5-1904</i>	
9. AGE (In years lost birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Stephen Ragan</i>				14. MOTHER'S MAIDEN NAME <i>Mabel Alexander</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>100-1-10000</i>			
17. INFORMANT <i>Brother B. Rudy</i> Address <i>Rt. # 3 Box 87A Bel Air, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>8 days</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/28</i> , 19 <i>58</i> to <i>11/4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/4</i> , 19 <i>58</i> , and that death occurred at <i>11:30</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Neil Taylor</i> M.D.				DATE, SIGNED <i>11/5/58</i>			
PHYSICIAN'S NAME (Type) <i>Neil Taylor M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-7-1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chestnut Level</i>		22d. LOCATION (City, town, or county) (State) <i>Lancaster Co., Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Son</i> ADDRESS <i>Perryville, Md.</i>				24a. REC'D BY REGISTRAR <i>NOV 7 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

1900

Name of Deceased		Sex		Age		Date of Death	
John V. Smith		Male		45		Jan 15, 1900	
Place of Birth		Usual Residence		Cause of Death		Died at	
Boston, Mass.		Boston, Mass.		Heart Disease		Home	
Occupation		Marital Status		Time of Death		Physician	
Clerk		Married		10:30 AM		Dr. J. H. Brown	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		Cause of Death		Died at	
Jan 15, 1900		Boston, Mass.		Heart Disease		Home	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12554

CERTIFICATE OF DEATH

12533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grounds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, APG, MD		e. STREET ADDRESS 5 West 63d Street	
3. NAME OF DECEASED (Type or print) First Albert Middle Charles Last BENZIO		4. DATE OF DEATH Month Nov Day 23 Year 19 58	
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Jul 1897
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - M Sgt		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II, Korean 119-07-3332	
17. INFORMANT Official US Army Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of signoid colon with metastases DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH probably over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1958 , to 23 Nov 1958 , that I last saw the deceased alive on 22 Nov 1958 , and that death occurred at 4:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 23 Nov 58			
ACTUAL SIGNATURE John Z. Delp M.D.		PHYSICIAN'S NAME (Type) JOHN Z. DELP	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Blight Inc.		ADDRESS 6009 Harford Rd, Balto. Md.	
24a. REC'D BY REGISTRAR DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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125555

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12534

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle J. Last BRAGG		4. DATE OF DEATH Month November Day 17 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Feb. 1867
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Samuel Bragg		14. MOTHER'S MAIDEN NAME Elizabeth Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 0ma Bragg, RD. 1, Aberdeen, Md.	
17. INFORMANT 0ma Bragg, RD. 1, Aberdeen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 17 , 19 58 , to Nov 17 , 19 58 , that I last saw the deceased alive on Nov 17 , 19 58 , and that death occurred at 3:45pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. J. Plunkett, Jr.		ADDRESS (Street, city or town, state) 617 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr., M.D.		DATE SIGNED 11-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-58	
22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR NOV 21 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

V5 A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

1917

DATE OF DEATH

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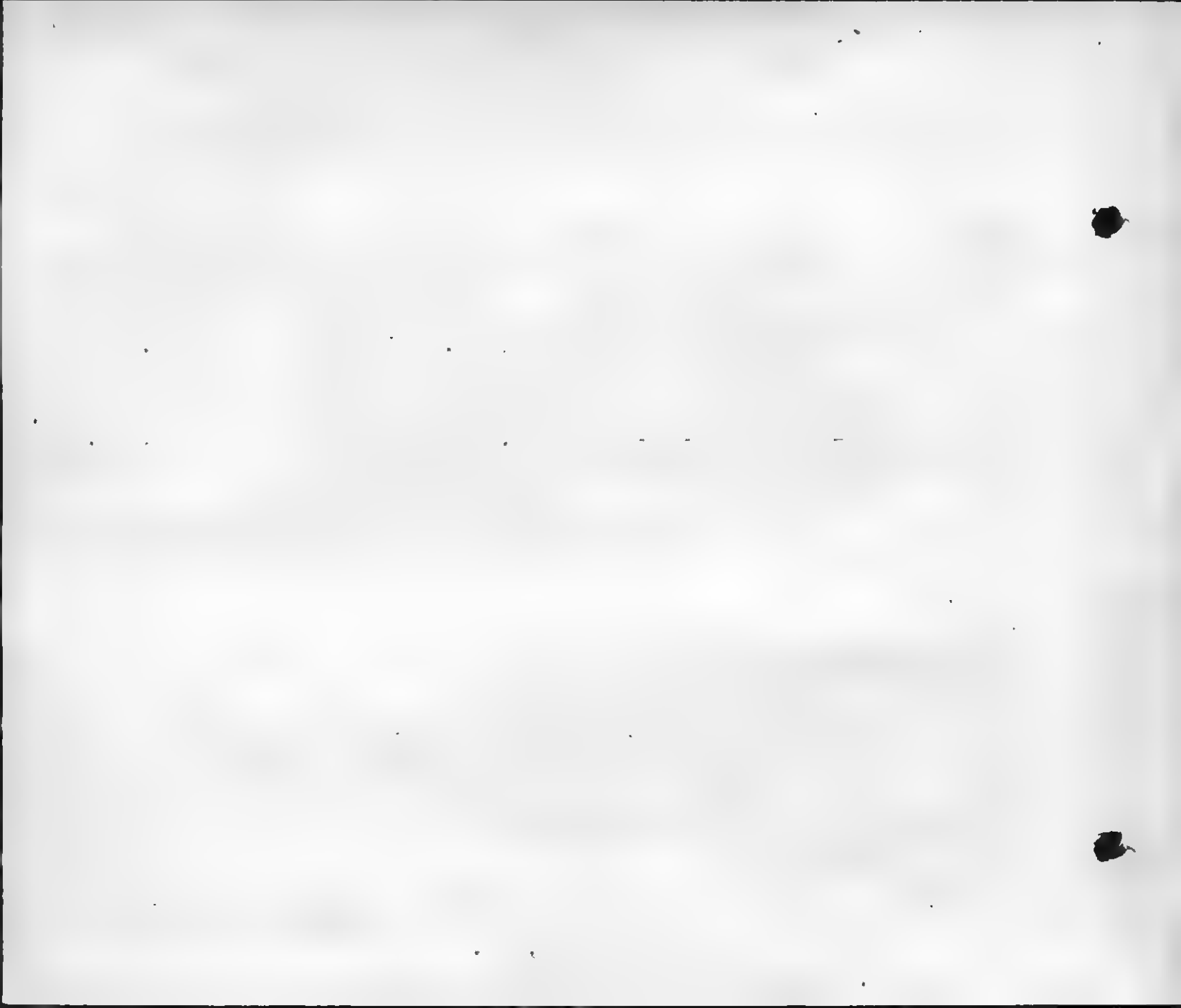
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle DELANO Last CHACK				4. DATE OF DEATH Month NOVEMBER Day 4 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 7 1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY Fire Department (APG.) Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME WILLIAM CHACK				14. MOTHER'S MAIDEN NAME MARGARET DELANO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-1				16. SOCIAL SECURITY NO. 220-22-0271			
17. INFORMANT Mrs. Georgia Clark				Address 522 Walker St. Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 443X Acute Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Arteriosclerotic Cardiovascular Disease 21 years (c). and Hypertensive Cardiovascular Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Anterior Coronary Thrombosis & subendocardial infarction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m. 7 19 58 p. m.							
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/19th 1958 to 11/4th 1958 , that I last saw the deceased alive on 11/4th 1958 , and that death occurred at 10:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 N. Union Ave. Harford, Md. DATE SIGNED Nov. 4th 1958 PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. Haver de Grace, Ind. at 10:50 PM							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Aberdeen, Md.				24a. REC'D BY REGISTRAR DATE NOV 10 58		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 11 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD #1 1 1/2 mile No. on Rt 1.</u>		d. STREET ADDRESS <u>RD #1 1 1/2 mile No. on Rt 1</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>LESLIE</u> Middle <u>COCHRAN</u> Last		4. DATE OF DEATH <u>NOVEMBER 10</u> 19 <u>58</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 14, 1882</u> 9. AGE (In years last birthday) <u>76</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW COCHRAN</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA LEWIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>220-22-2295</u> 17. INFORMANT <u>Wife - Nora Cochran - same.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIO-SCLEROSIS</u> (a), stating the underlying cause last. DUE TO (c) <u>UNK</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SOMIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>NOV 10, 1958</u>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 13 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>	22d. LOCATION (City, town, or county) <u>Farmers</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Archer Benson Md</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

I

124



12536

CERTIFICATE OF DEATH

12536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			
c. LENGTH OF STAY IN 1b <u>3 wks.</u>				d. STREET ADDRESS <u>264 Lewis St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Connors</u> Last <u>Connors</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>		11. IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Clara A. Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give water dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Self</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
DUPLICATE DUE TO (b) <u>Cor Pulmonale</u> <u>2 years</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Pulmonary Fibrosis</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hips Left</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Slipped in house 10/6/58</u>			
20c. TIME OF INJURY Month <u>10</u> Day <u>6</u> Year <u>1958</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Harre de Grace Harford Md</u> (County) (State)			
21. I certify that I attended the deceased from <u>10/6/58</u> to <u>11/1/58</u> , that I last saw the deceased alive on <u>10/8/58</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Harre de Grace Md</u> DATE SIGNED <u>1</u>							
ACTUAL SIGNATURE <u>Irvin L. Wachsman M.D.</u>				PHYSICIAN'S NAME (Type) <u>IRVIN L. WACHSMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or county) <u>Joppa Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer Benson Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>NOV 5 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. H. Archer Benson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12556

CERTIFICATE OF DEATH

Reg. Dist. No.

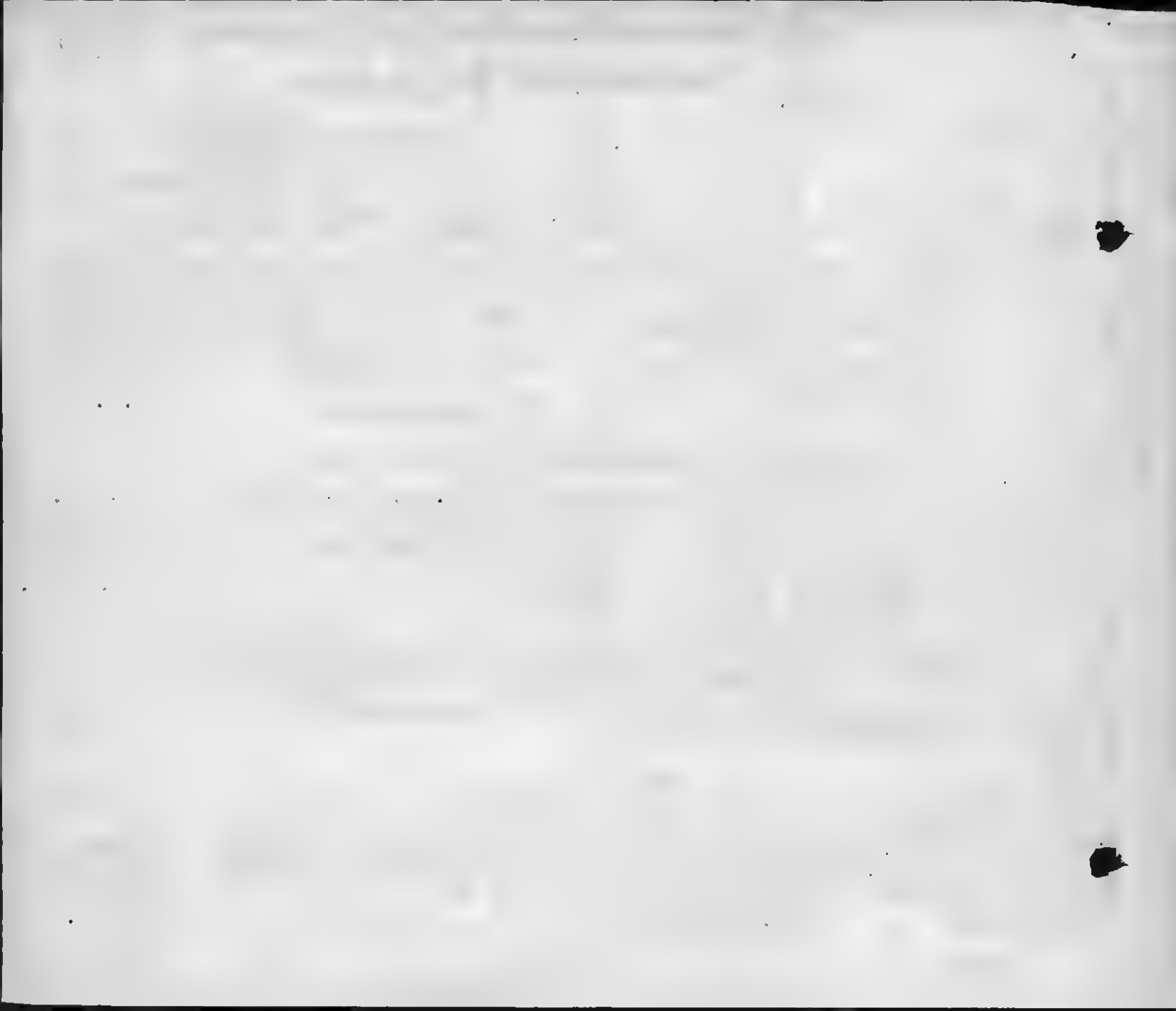
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY <u>Jarrettsville</u>		CITY <u>Jarrettsville</u>	
CITY OR TOWN <u>Jarrettsville</u>		LENGTH OF STAY (in this place) <u>44 yrs.</u>		TOWN <u>Jarrettsville</u>		STREET ADDRESS <u></u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u></u>				STREET ADDRESS <u></u> (if rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>Carrie Neal Gross</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 30, 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 19, 1876</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Norricville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Neal</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Fletcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Dr. A. James Gross, Look, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				prob. 15 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>2010 Fracture, Left Femur - post operative.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/11/53</u> , 19 <u>53</u> to <u>11/30/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/29/58</u> , 19 <u>58</u> , and that death occurred at <u>8:52 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>12/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THREOF <u>Dec. 3, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		LOCATION (City, town, or county) (State) <u>Jarrettsville Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 5 '58</u>		REGISTRAR'S SIGNATURE <u>C. W. S. S. S.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. G. Keary</u>		ADDRESS <u>Jarrettsville Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet Grace</u> c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>720 Linden Lane</u>	
3. NAME OF DECEASED (Type or print) <u>George Washington Hessinger</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1925</u>
9. AGE (In years last birthday) <u>33</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Print Photo</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. W. Hessinger</u>		14. MOTHER'S MAIDEN NAME <u>Rallie Delf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Helen V. Hessinger</u>		Address <u>720 Linden Lane Hamlet Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>824X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident - load shifted onto him</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a. m. <u>11-3</u> 1955		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>Route 40</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>Edgewood</u>		20f. (City or town) (County) (State) <u>Harford MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>11-3-55</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/6/55</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barryton & Co, Hamlet Grace, MD</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '55</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12541

FOR STATE HEALTH DEPT.

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> c LENGTH OF STAY IN 1b _____ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2 USUAL RESIDENCE (Where deceased lived. If institut an Residence before adm sign) a STATE <u>Md</u> b COUNTY <u>Harford</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> d STREET ADDRESS _____ e IS RESIDING ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Dorothy May Holloway</u> 5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH <u>August 2, 1958</u> 9 AGE (In years last birthday) <u>3</u> 10a USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) _____ 10b KIND OF BUSINESS OR INDUSTRY _____ 11 BIRTHPLACE (State or foreign country) <u>Harford, Md</u> 12 CITIZEN OF WHAT COUNTRY? <u>US</u>		4 DATE OF DEATH <u>November 25, 1958</u> 9 AGE (In years last birthday) <u>3</u> 10c <u>Months</u> <u>3</u> Days <u>3</u> Hours <u>11</u> Min <u>58</u> 13 FATHER'S NAME <u>Jessie Holloway</u> 14 MOTHER'S MAIDEN NAME <u>ANNA MAY ANDERSON</u> 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16 SOCIAL SECURITY NO _____ 17 INFORMANT <u>MRS ANNE MAY HOLLOWAY</u> <u>Forest Hill Md</u> 	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>144-5X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity (8 mos)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>11-26-58</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b DATE THEREOF <u>Nov 26/58</u> 22c NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist</u> 22d LOCATION (City, town, or county) <u>Bel Air, Md</u> (State) <u>Md</u> 22e FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lato</u> ADDRESS <u>Bel Air Md</u> 24a REC'D BY REGISTRAR <u>DEC 9 '58</u> 24b REGISTRAR'S SIGNATURE _____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

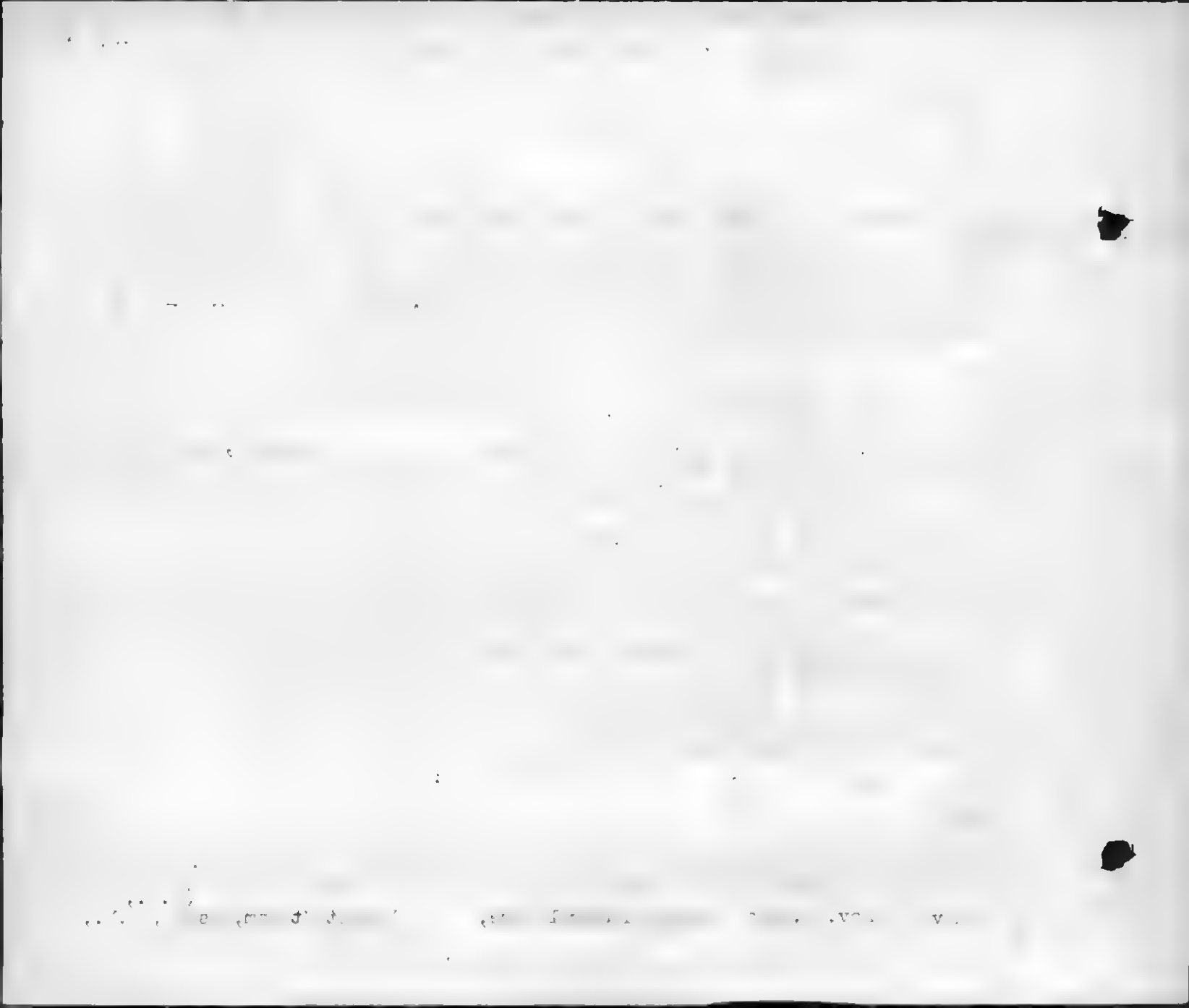
12542

12558

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHRYN Middle GLADYS Last KESSLER				4. DATE OF DEATH Month November Day 27 Year 19 58			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1958	
9. AGE (In years last birthday) yrs. 0		IF UNDER 1 YEAR Months - Days - Hours 13 Min. 19		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Stowell Van Courtland Kessler				14. MOTHER'S MAIDEN NAME Gladys Ruth Combes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		(If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. None		17. INFORMANT Father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Totem Pole Trailer Park Edgewood, Maryland				INTERVAL BETWEEN ONSET AND DEATH 3 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 0350 hrs to 0400 hrs , that I last saw the deceased alive on Never , 12 Nov , 19 58 , and that death occurred at 3:50 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ivan W Sletten M.D. US ARMY HOSPITAL				27 Nov 58			
PHYSICIAN'S NAME (Type) IVAN W SLETTEN CAPT MC				ABERDEEN PROVING GROUND, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Moore Funeral Home,		22d. LOCATION (City, town, or county) (L.I.,) (State) Valley Stream, Nassau, N.Y.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R McCombs				ADDRESS Abingdon Tid		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Frank	



12559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adam Jerome Klock</u>		4. DATE OF DEATH Month Day Year <u>November 9 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Charles M. Klock</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia O'Malley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>220-20-7536</u>	
17. INFORMANT <u>Jerome J. Kolch, Chambersburg, Penna.,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <u>B. Blair, Md.</u> DATE SIGNED <u>11-10-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McGowan Jr</u>		24a. REC'D BY REGISTRAR <u>Abingdon, Md.,</u> DATE <u>NOV 14 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12560 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall P.O.</u>	
c. LENGTH OF STAY IN 1b <u>8 years</u>		d. STREET ADDRESS <u>Hitchcock Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hitchcock Road</u>			
3. NAME OF DECEASED (Type or print) <u>Seward Roswell Kriesge</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5, 1885</u>
9. AGE (in years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister of the Gospel Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monroe Co. Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alford S. Kriesge</u>		14. MOTHER'S MAIDEN NAME <u>Savanna Brong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-4863</u>	
17. INFORMANT <u>Valeria H. Kriesge</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>BE Air Md</u> DATE SIGNED <u>11-16-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baust Church</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion G. Hutz</u>		24a. REC'D BY REGISTRAR <u>Nov 20 '58</u>	
ADDRESS <u>Jennettsville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION



12538

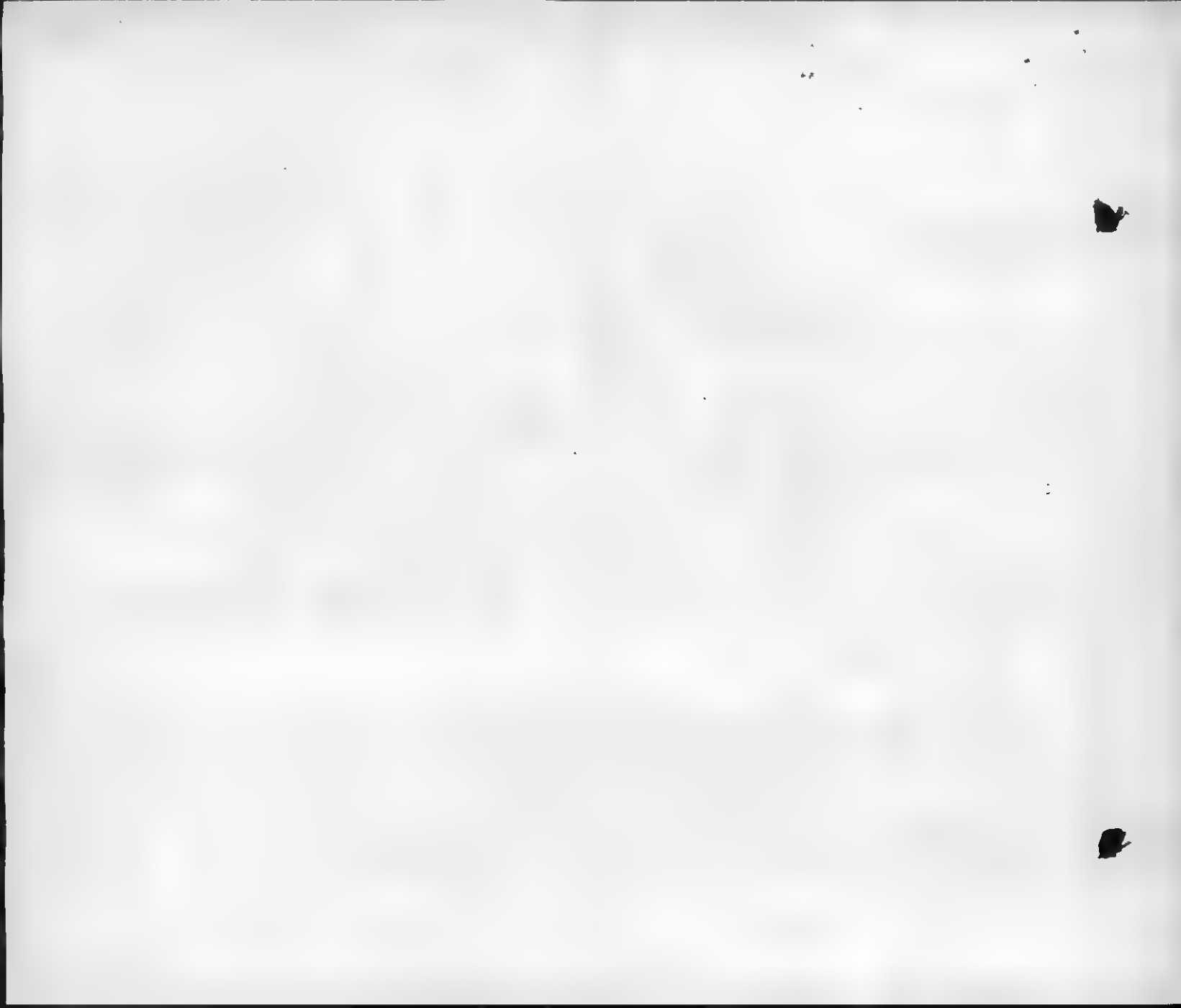
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamde Bruce</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamde Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>301 S. Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene H. Latta</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Burlington N.J.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene A. Latta</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Robbins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Robert L. Latta</u>		Address <u>Berkeley N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>291X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic C.V. disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL-CREATION, REMOVAL (Specify) <u>11/10/58</u>	22b. DATE THEREOF <u>11/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>	22d. LOCATION (City, town, or county) (State) <u>Berkeley N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levy & Co.</u>		24a. REG'D BY REGISTRAR <u>NOV 13 '58</u>	
ADDRESS <u>Hamde Grace, Md</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harpford</u>		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harpford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Krohn's Cleaners</u>		d. STREET ADDRESS <u>Krohn's Cleaners</u>	
3. NAME OF DECEASED (Type or print) <u>John Edward Maloney</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/16</u> <u>11/9/14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <u>Shamokin, Pennsylvania</u>	
13. FATHER'S NAME <u>Edward Maloney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaughan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>178-05-1512</u>	
17. INFORMANT <u>Mrs. A. Walters</u>		Address <u>Mrs. A. Walters</u> <u>1120 d. Pine St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IPHEDALITY</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (a), stating the underlying cause lost.		Alcoholism INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Lester E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>11-8-58</u>	
EXAMINER'S NAME (Type) <u>George E Palmer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Edwards</u>		22d. LOCATION (City, town, or county) (State) <u>Shamokin Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Foster</u>		24a. REC'D BY REGISTRAR <u>Bel Air Md</u> DATE <u>NOV 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12561 CERTIFICATE OF DEATH

12546

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlingen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlingen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James P. McCracken</u>		4. DATE OF DEATH <u>Nov 6</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>1895</u> 6 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. res.) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Washington Co., Va.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <u>No</u>		17. INFORMANT <u>Everett J. McCracken</u>	
16. SOCIAL SECURITY NO. <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO <u>Brain Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain Infection</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain Infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 5</u> , 19 <u>58</u> , to <u>Nov 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 6</u> , 19 <u>58</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. P. Smidgrass</u> M.D. <u>58</u>		ADDRESS (Street, city or town, state) <u>Harlingen, MD</u>	
PHYSICIAN'S NAME (Type) <u>F. P. Smidgrass</u>		DATE SIGNED <u>Washington Co. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 8, 1958</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Houbler Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>



12540

Item # 5236 12-12-58 et

CERTIFICATE OF DEATH

12548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>70 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Rural # 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Murray R. Moretz</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 30 1958</u>																					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/1905</u>		9. AGE (In years last birthday) <u>53</u> yrs. <table border="1" style="display: inline-table; font-size: small;"> <tr> <th colspan="4">IF UNDER 1 YEAR</th> <th colspan="4">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td><td>Days</td><td>Hours</td><td>Min.</td> <td>Months</td><td>Days</td><td>Hours</td><td>Min.</td> </tr> </table>		IF UNDER 1 YEAR				IF UNDER 24 HRS				Months	Days	Hours	Min.	Months	Days	Hours	Min.
IF UNDER 1 YEAR				IF UNDER 24 HRS																					
Months	Days	Hours	Min.	Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																	
13. FATHER'S NAME <u>Vance Governor Moretz</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (Green)</u>																					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>224-12-6129</u>		17. INFORMANT Address <u>Mrs. Leslie Jones Aberdeen R. 7th 2nd rd.</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <table border="1" style="width:100%; font-size: small;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Chronic Passive Congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2"> (b) <u>Mitral Stenosis & Cardiac Eng.</u> </td> <td colspan="2"> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> </td> </tr> <tr> <td colspan="2"> (c) <u>Rheumatic Fever</u> </td> <td colspan="2"></td> <td colspan="2"> <u>?</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Chronic Passive Congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Mitral Stenosis & Cardiac Eng.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		(c) <u>Rheumatic Fever</u>				<u>?</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Chronic Passive Congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Mitral Stenosis & Cardiac Eng.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>																					
(c) <u>Rheumatic Fever</u>				<u>?</u>																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>50</u> , to <u>Nov 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 30</u> , 19 <u>58</u> , and that death occurred at <u>3:25 P.</u> M, from the causes and on the date stated above.																									
ACTUAL SIGNATURE <u>Ralph Horky</u> M.D.						ADDRESS (Street, city or town, state) <u>Churchville</u>																			
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky MD</u>						DATE SIGNED <u>DEC 1 1958</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/2/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Independence Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Independence Virginia</u>																	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John G. Darring Aberdeen, Md.</u>						24. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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The above is the
list of the
names of the
persons who
have been
admitted to
the office of
the
Secretary of
the
Board of
Education
of the
City of
New York
for the
year 1902.

2002
5.
5.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

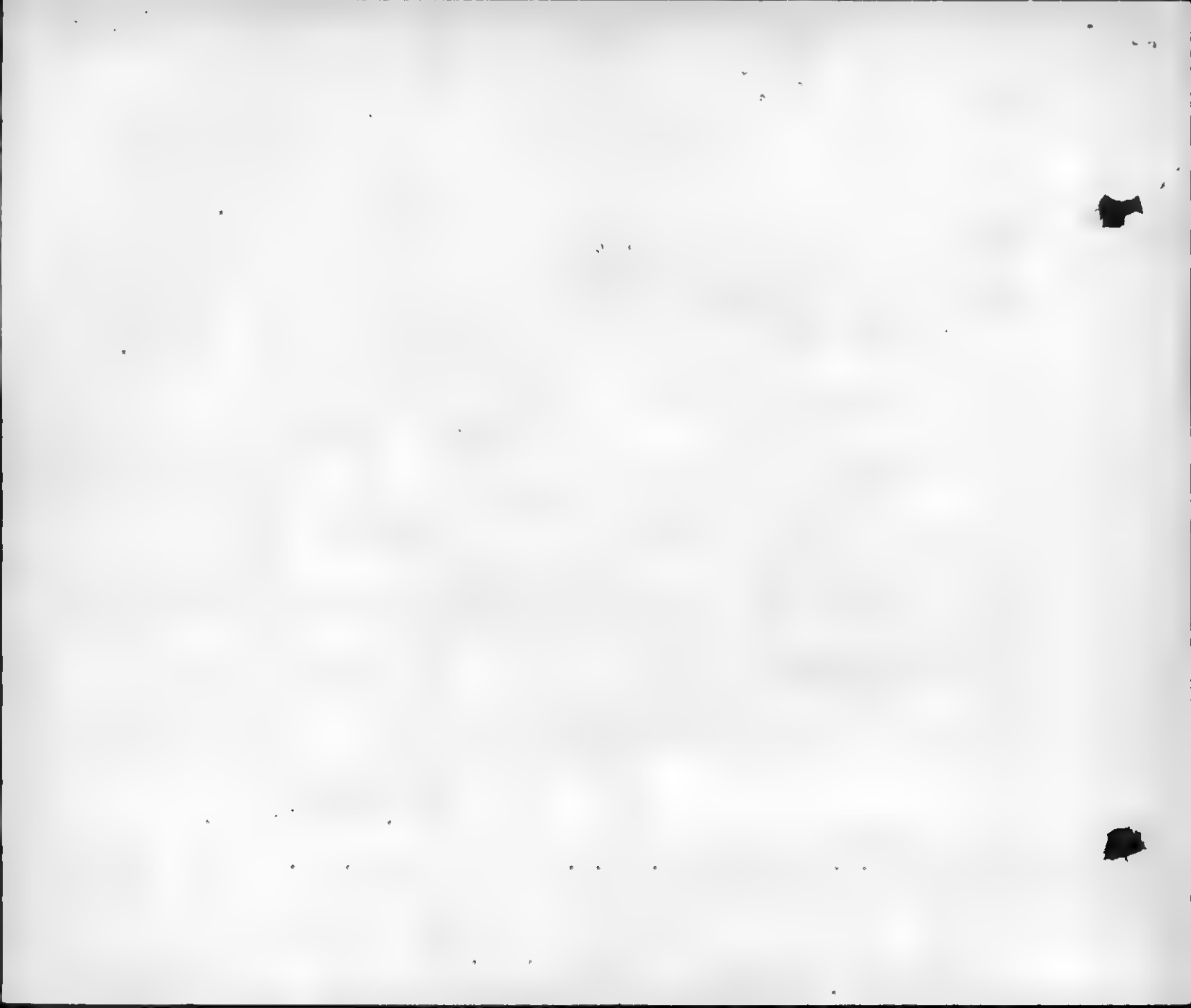
12541

CERTIFICATE OF DEATH

12549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
f. STREET ADDRESS <u>403 Watervliet St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Moura</u> Last <u>Moura</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Married</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-58</u>
9. AGE (In years, last birthday) yrs <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph Sousa Moura</u>		14. MOTHER'S MAIDEN NAME <u>Sheila Perkins.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Joseph Moura. 403 Watervliet St. Abdr Md</u>	
17. INFORMANT Address <u>Joseph Moura. 403 Watervliet St. Abdr Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 hrs</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1, 1958</u> to <u>Nov 1, 1958</u> , that I last saw the deceased alive on <u>Nov 1, 1958</u> , and that death occurred at <u>5:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. Bel Air Ave.</u> DATE SIGNED <u>11-2-58</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		M.D. <u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



12563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Martin Luther Phillips</u>		4. DATE OF DEATH <u>Nov 3 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20th 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Tarrettsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia Arthur</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary F Phillips</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, chronic myocarditis,</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis, chronic</u> DUE TO (c) <u>prostate m.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 15, 1958</u> , to <u>Nov. 3, 1958</u> , that I last saw the deceased alive on <u>Nov. 1, 1958</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Norman H. Gemmill</u> M.D.		DATE SIGNED <u>Nov 3, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kuntz</u>		24a. REC'D BY REGISTRAR <u>Nov 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kuntz</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12542

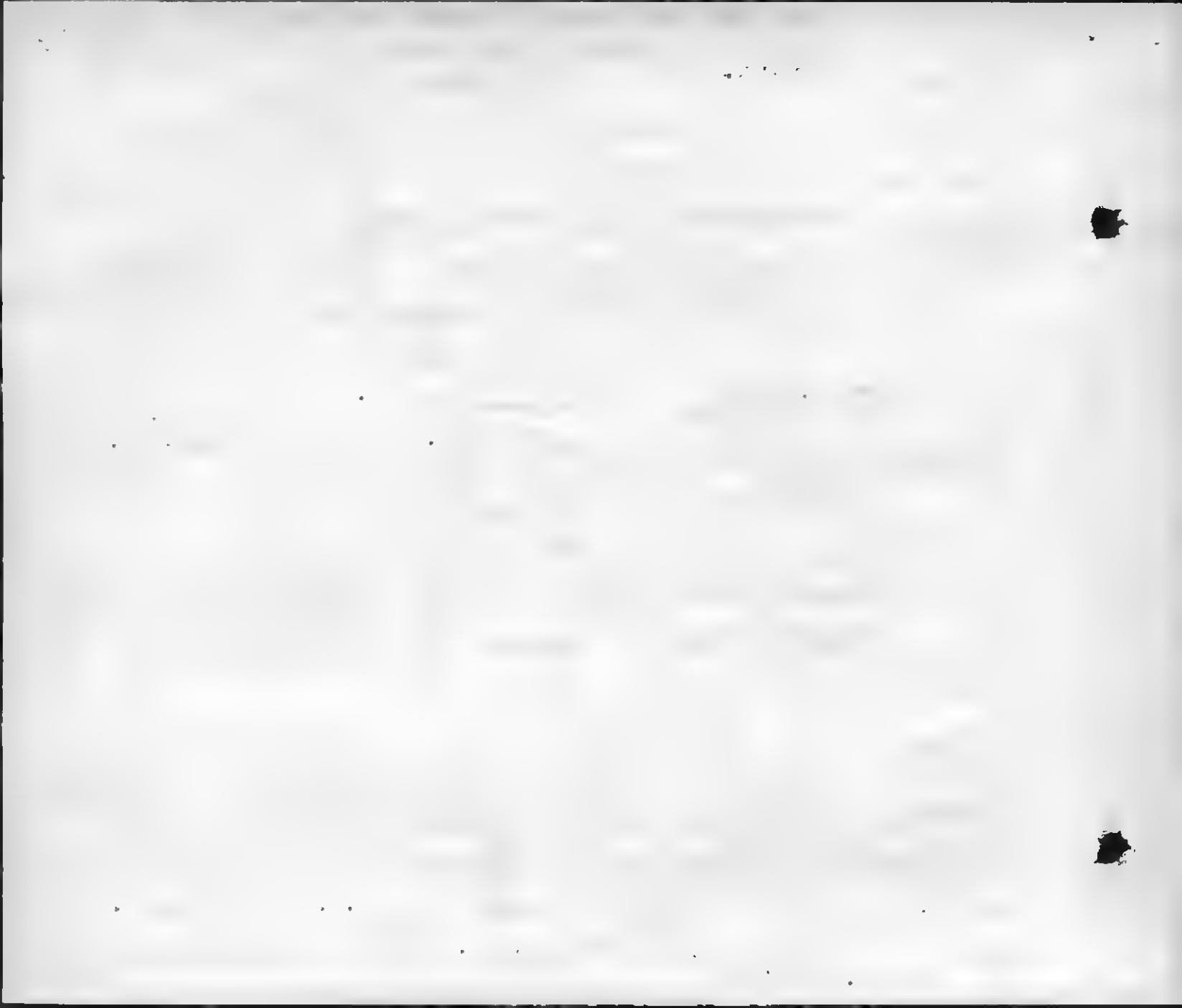
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>			
f. STREET ADDRESS <u>21 E. BELAIR</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RANDY KEVIN PLUFF</u>				4. DATE OF DEATH Month Day Year <u>November 3 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-58</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>3 12</u>	IF UNDER 24 HRS <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Addison E. Pluff</u>				14. MOTHER'S MAIDEN NAME <u>Ginger E. Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Addison E. Pluff</u>		Address <u>21 E. Bel Air</u> <u>Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA AND ATELECTASIS</u> <u>100%</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>58</u> , to <u>11/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>11:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 N. UNION AVE.</u> DATE SIGNED <u>11/5/58</u>							
ACTUAL SIGNATURE <u>John G. Tarring</u> M.D. <u>200 N. UNION AVE.</u>				DATE SIGNED <u>11/5/58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN RANDALL ROSS</u> <u>HAVER DE GRACE, MD.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> John G. Tarring				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>John G. Tarring</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12543

CERTIFICATE OF DEATH

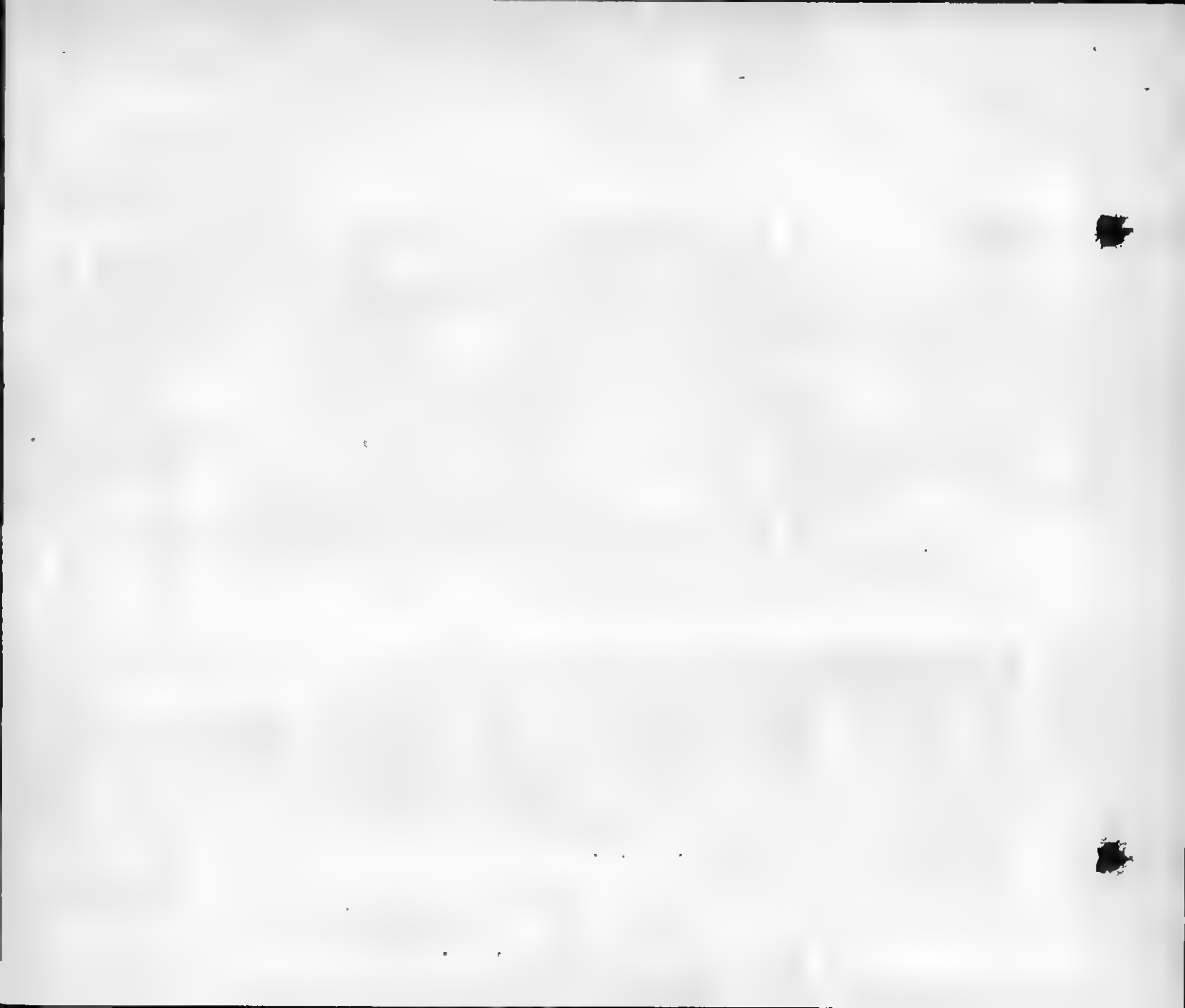
12553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVET DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PERRYMAN</u>			
f. STREET ADDRESS <u>Box 105</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLY</u> <u>DOUGLAS</u> <u>POE</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 21</u> <u>19</u> <u>58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 April 1958</u>	
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>		IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donnell L. Poe</u>				14. MOTHER'S MAIDEN NAME <u>Estella Bowden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** **</u>		17. INFORMANT Address <u>Donnell L. Poe, Box 105, Perryman, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>SUCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Laryngo-tracheal Bronchitis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4.2.58</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/19/58</u> , to <u>11/21/58</u> , that I last saw the deceased alive on <u>11/21/58</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin Wachsman</u> M.D.				ADDRESS (Street, city or town, state) <u>Harvett de Grace, Md.</u>		DATE SIGNED <u>11/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Irwin Wachsman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12544

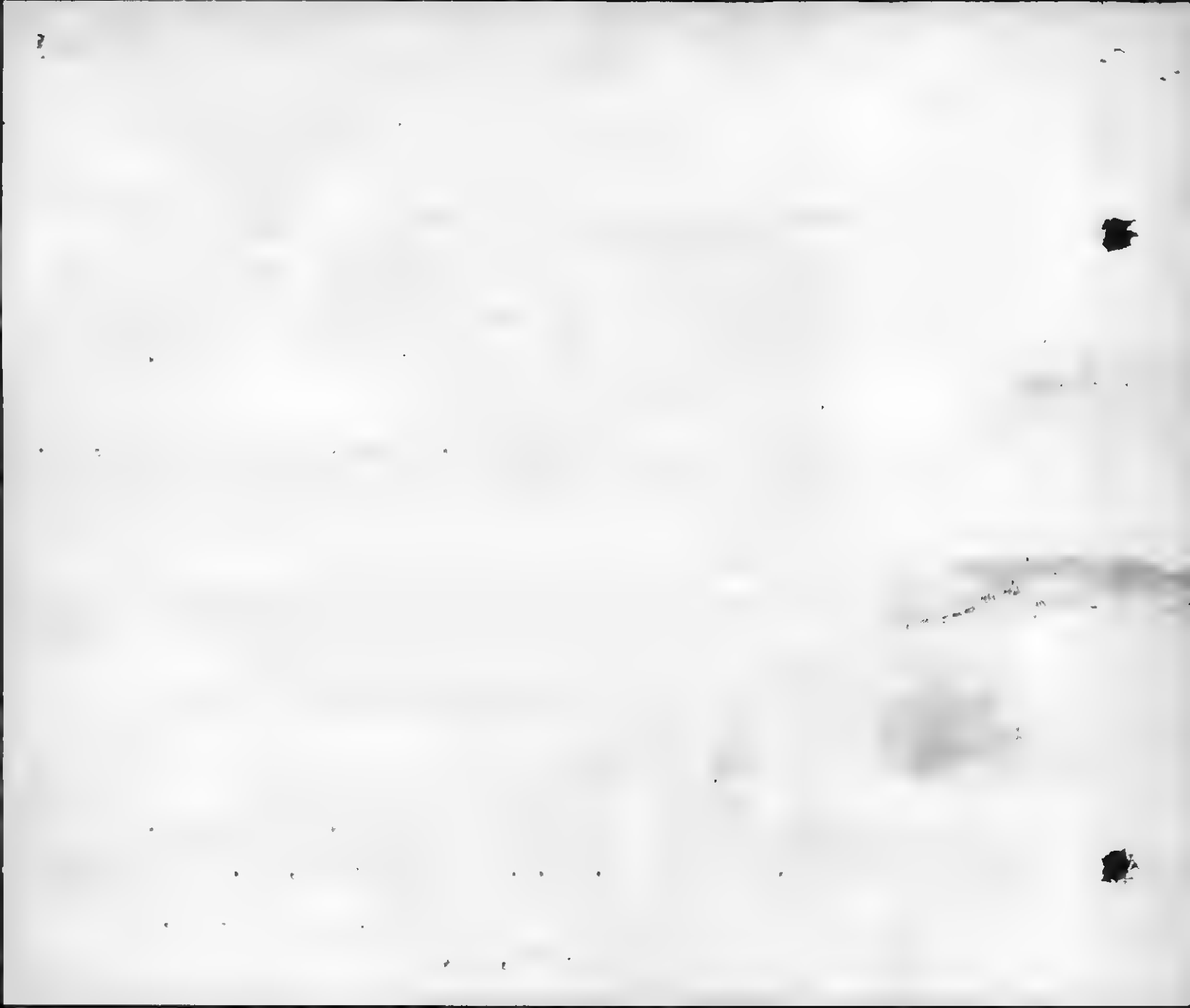
CERTIFICATE OF DEATH

12554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 515 Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STELLA Middle GERTRUDE Last SAYERS		4. DATE OF DEATH Month November Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 March 1908
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Henry J. Bragg		14. MOTHER'S MAIDEN NAME Onie Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles T. Sayers,		Address 515 Franklin St Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of ovary metastatic (generalized) 1730 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 7, 1958 to Nov 1, 1958 , that I last saw the deceased alive on 11-1, 1958 , and that death occurred at 1:42 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. DATE SIGNED ACTUAL SIGNATURE Barry J. Plunkett Jr. M.D. PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D. Aberdeen, Md. 11/3/58			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/58	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens,		22d. LOCATION (City, town, or county) (State) Bel Air, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md. 24a. REC'D BY REGISTRAR DATE NOV 5 '58 24b. REGISTRAR'S SIGNATURE Clifton S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12564

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIAL HAVREDEGRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIAL HAVREDEGRACE MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIFE CATHARINE S. ADAMS</u>				4. DATE OF DEATH Month Day Year <u>NOV 14 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 4 1915</u>	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE F. F. F.</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ANTHON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>HAMMOND X. ADAMS</u> Address <u>HA 11115 45</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accidents</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1950</u> , to <u>Nov 14, 1958</u> , that I last saw the deceased alive on <u>Nov 13, 1958</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/16/58</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>				<u>Darlington MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>Nov 16/58</u>		<u>HA 11115 45</u>		<u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be emitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 12-11-58 et

12556

12545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Convalescing Home</u>	
d. NAME OF DECEASED (Type or print) <u>Ottomar Schreiber</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ottomar Schreiber</u>		4. DATE OF DEATH <u>November 26 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>Phila, Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ottomar Schreiber</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Walter Nursing Home</u>		17. INFORMANT <u>Walter Nursing Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V Disease</u> <u>22.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>58</u> , to <u>Nov. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>58</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>11-26-58</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov. 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Phila, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Marlington</u>		24. REG'D BY REGISTRAR <u>Dec 1 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Robert S. Krawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12546

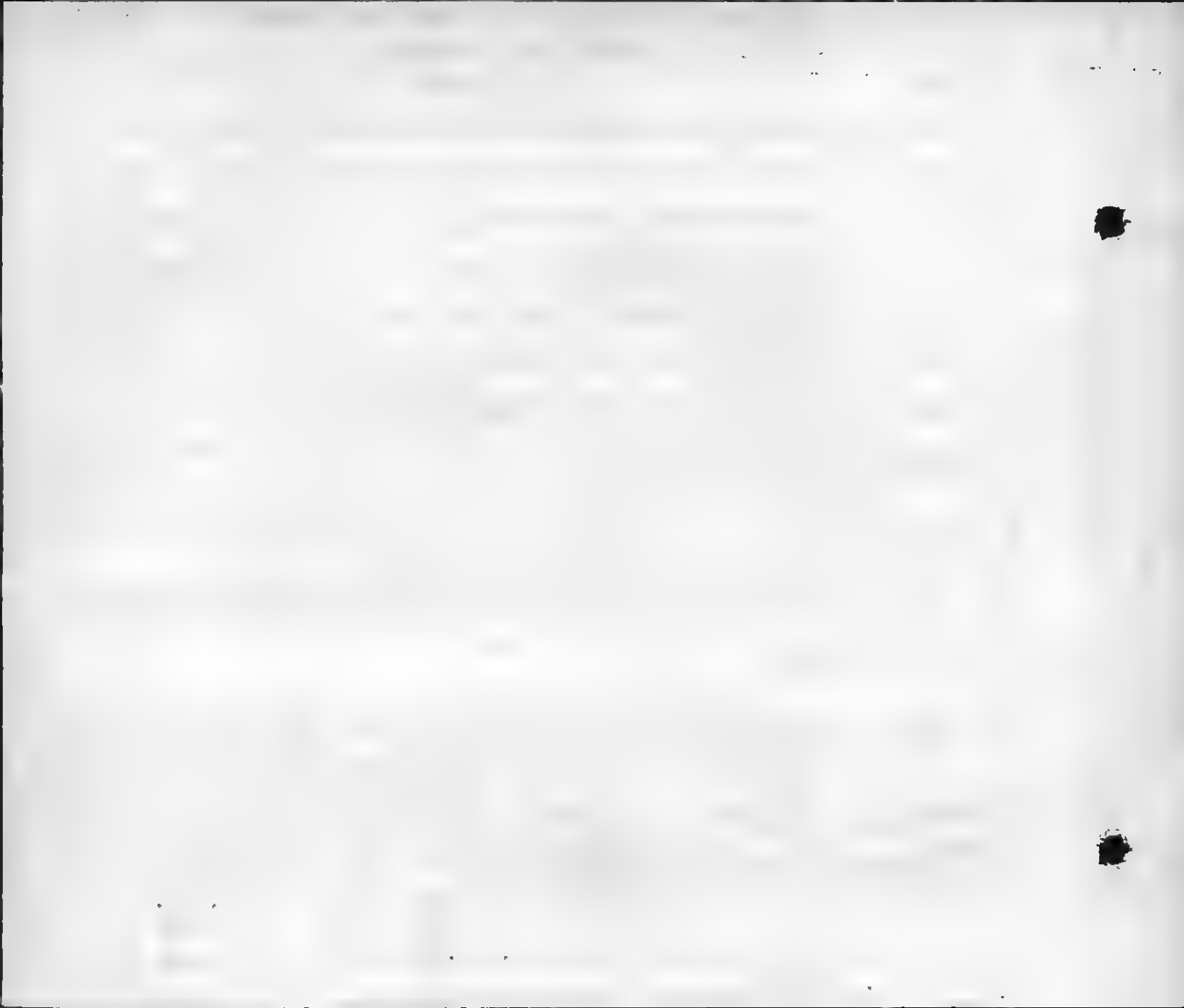
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS 10 HRS</u> x <u>ABERDEEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL LEIGH SEXTON</u>				4. DATE OF DEATH Month Day Year <u>11 2 19 58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-58</u>	
9. AGE (In years last birthday) <u>24</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>CHARLES DEAN SEXTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY LOU BROWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u>							
DUE TO (b) <u>ATELECTASIS</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/27, 1958</u> , to <u>11/2, 1958</u> that I last saw the deceased alive on <u>11/2, 1958</u> , and that death occurred at <u>4:03 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D.				DATE SIGNED <u>11/3/58</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>				<u>HAURE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welcome Home Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>RD. Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kead</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12547

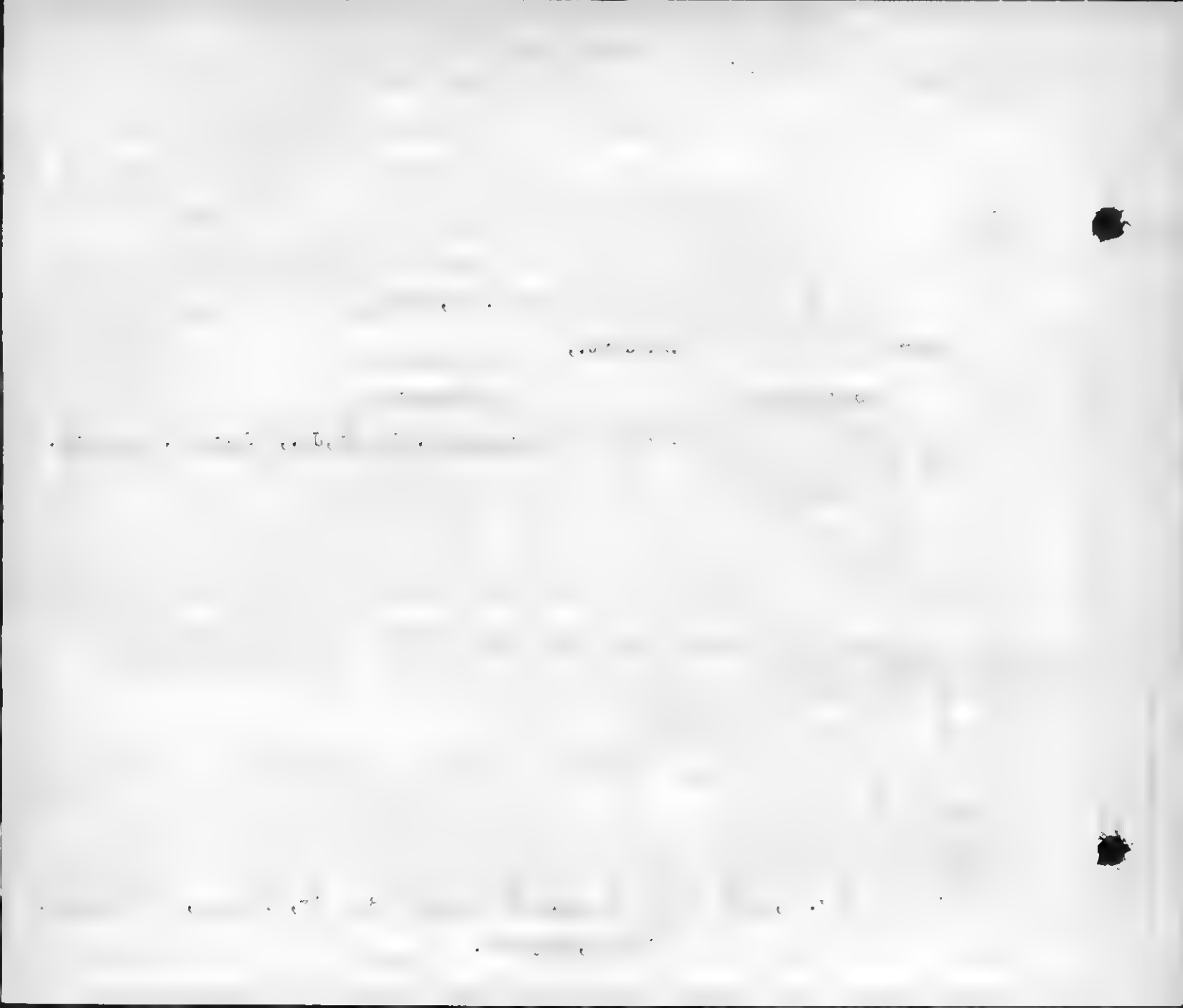
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
f. STREET ADDRESS <u>20 Oak Street</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Winfred Wilson Snyder</u>				4. DATE OF DEATH Month Day Year <u>November 9 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 23, 1884</u>	
9. AGE (In years, last birthday) <u>73 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>235-14-1964</u>		17. INFORMANT Address <u>Winfred W. Snyder, Jr., Edgewood, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Symptomatic myocardial infarction</u> DUE TO <u>arteriosclerosis, hypertension, and atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO <u>arteriosclerosis, hypertension, and atherosclerosis</u> (c) <u>arteriosclerosis, hypertension, and atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 weeks of severe influenza, pleurisy, and pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/3</u> , 19 <u>58</u> , to <u>11/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 9</u> , 19 <u>58</u> , and that death occurred at <u>1:15</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 766 Edgewood, Md.</u> DATE SIGNED <u>11/16/58</u>							
ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. Louis Kahan MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12565

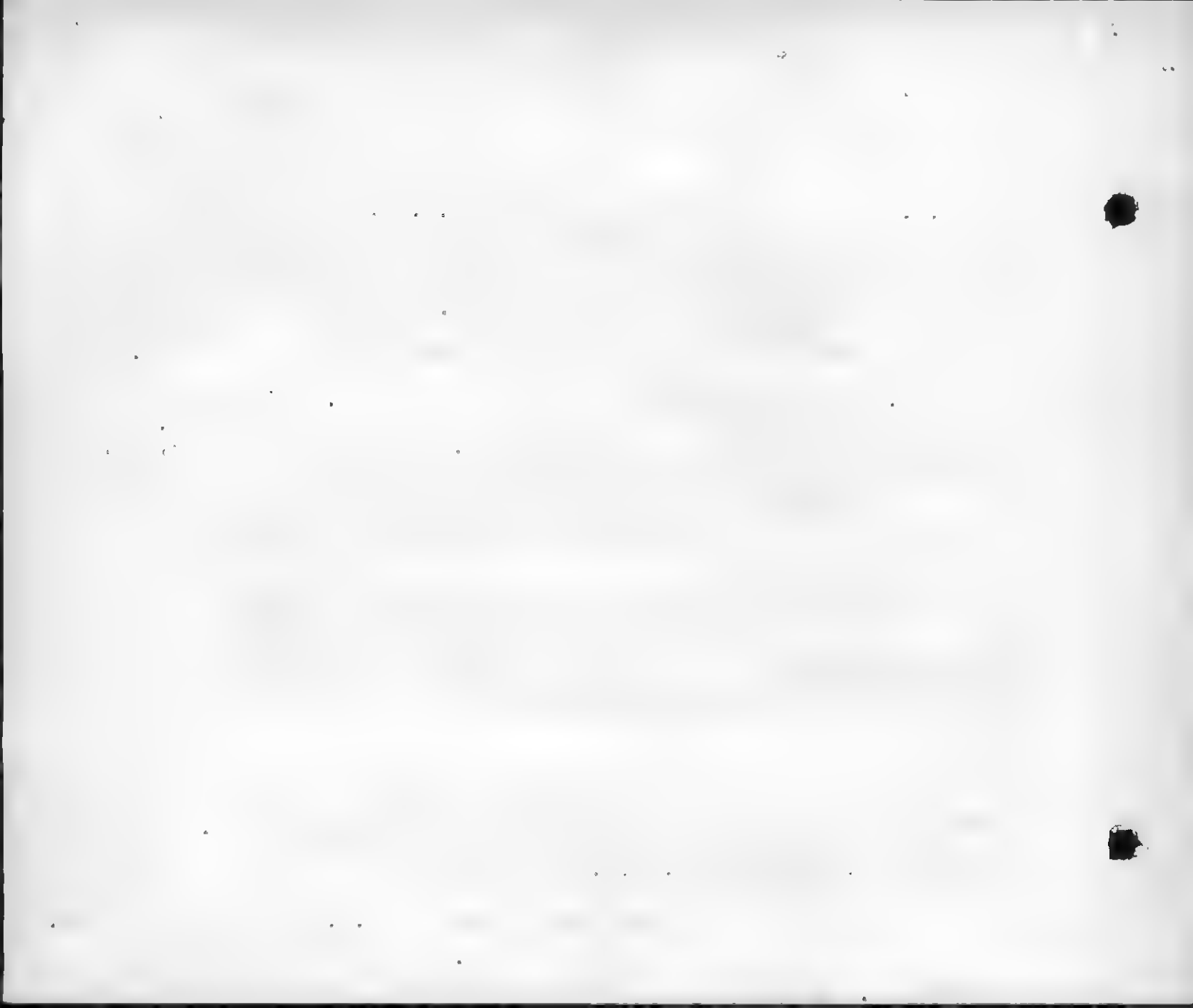
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1, Box 240		f. STREET ADDRESS R.D. 1, Box 240	
3. NAME OF DECEASED (Type or print) First CLARA Middle MARTHA Last STREETT		4. DATE OF DEATH Month November Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Nov. 1908
9. AGE (In years last birthday) yrs 49		IF UNDER 1 YEAR Months 2 Days 2 Hours 58 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME G. Clifton Everist		14. MOTHER'S MAIDEN NAME Estella C. McCommons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Milton E. Streett	
17. INFORMANT Milton E. Streett		Address R.D. 1 Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X asphyxia DUE TO Bilateral Primary Ca. Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 mo DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Weakness Muscles			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1950 to Oct. 1958 , that I last saw the deceased alive on Nov 1, 1958 AM and that death occurred at 4:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED 11/3/58			
ACTUAL SIGNATURE J. Ralph Horky, M.D.		PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/58	22c. NAME OF CEMETERY OR CREMATORY Rock Run Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Havre de Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR DATE NOV 5 58
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12548

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 21 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) HARFORD MEMORIAL Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X STREET	
3. NAME OF SWANN (Type or print) First Middle Last		4. DATE OF DEATH NOVEMBER 26 19 58 Month Day Year	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-58
9. AGE (In years last birthday) 21 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 21 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY NEWBORN	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Swann		14. MOTHER'S MAIDEN NAME HELEN LOUISE Higgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: a. IMMEDIATE CAUSE (a) Atelectasis of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 25, 1958 to Nov 26, 1958 , that I last saw the deceased alive on Nov 26, 1958 , and that death occurred at 1:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. J. Plunkett Jr		DATE SIGNED 11-26-58	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMAINS (Specify)	22b. DATE THEREOF 11-26-58	22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL	22d. LOCATION (City, town, or county) (State) Haure de Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Ziegler		ADDRESS Administrator	
24a. REC'D BY REGISTRAR DADEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DARLINGTON		c. LENGTH OF STAY IN 1b 62 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle ELLEN Last THOMAS		4. DATE OF DEATH Month NOV. Day 22 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 8, 1872
9. AGE (In years, months, days) 86 yrs		10. IF UNDER 1 YEAR Months 8 Days 6 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STOCKTON HOLDEN		14. MOTHER'S MAIDEN NAME MARTHA STEWART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. HAROLD A. JONES, DARLINGTON, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal ganglia thrombosis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infamy of Age DUE TO (c) Myocarditis			
INTERVAL BETWEEN ONSET AND DEATH Oct 25, 1958 1958 3 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 411X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25, 1958 , to Nov 22, 1958 , that I last saw the deceased alive on Nov 21, 1958 , and that death occurred at 1:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. P. Spradgrass M.D.		ADDRESS (Street, city or town, state) Darlington, Maryland	
PHYSICIAN'S NAME (Type) F. P. Spradgrass		DATE SIGNED Nov 23/58	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-58	
22c. NAME OF CEMETERY OR CREMATORY DARLINGTON		22d. LOCATION (City, town, or county) (State) DARLINGTON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE William E. Hines			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

VS A15 (4)
15M 10/57



12549

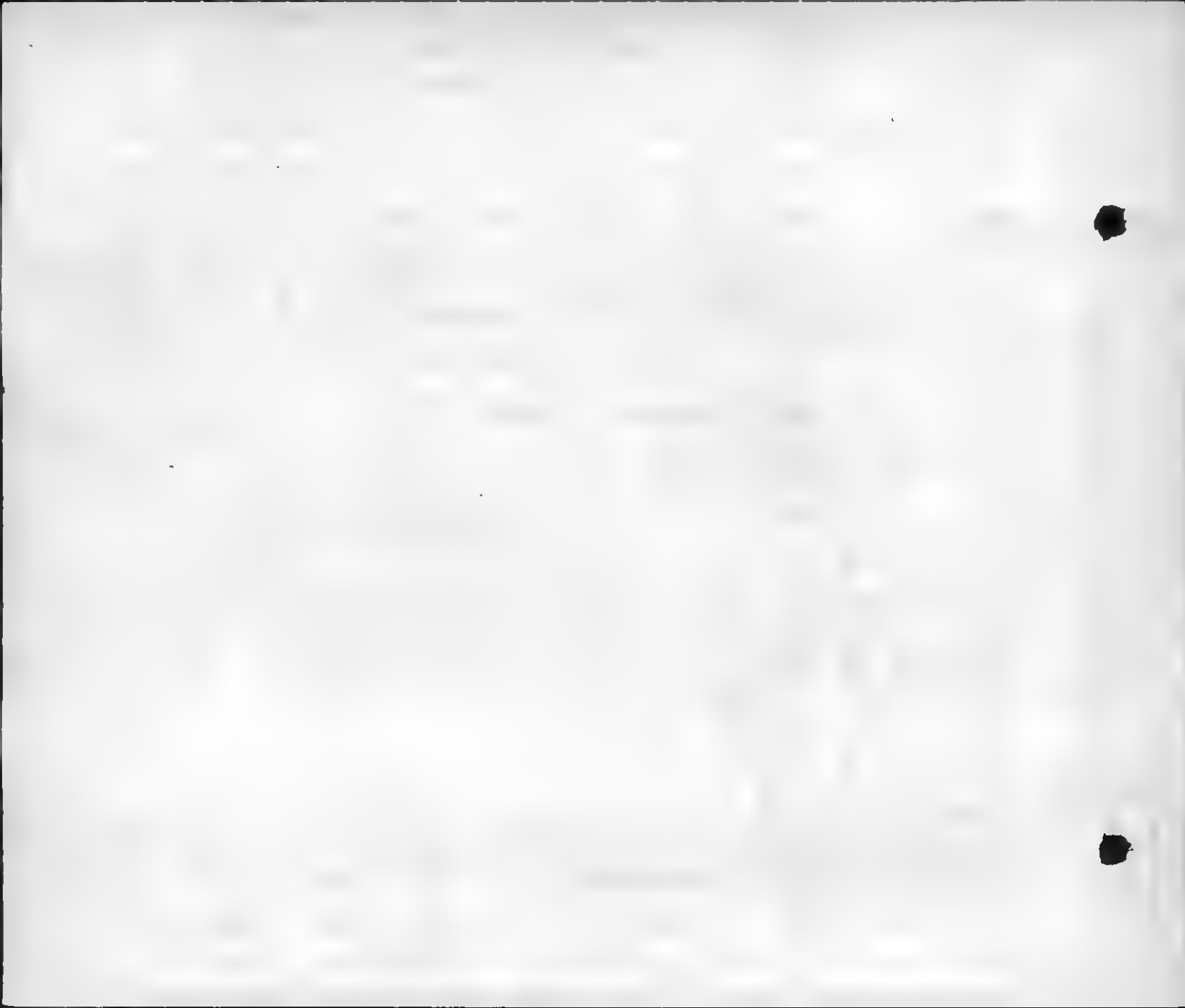
CERTIFICATE OF DEATH

12562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD d. STREET ADDRESS 626 PEARL ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GRACE MAY WARD				4. DATE OF DEATH Month Day Year NOVEMBER 16 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1899 11/7/1899	
9. AGE (In years last birthday) 59 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL ENGLE				14. MOTHER'S MAIDEN NAME MARY SOIT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 10-11-58-11-11-11		17. INFORMANT Wm. S. Ward - Harford, Md. Address Harford, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 422.1 DUE TO Arterio-sclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10, 1958 to Nov 16, 1958 , that I last saw the deceased alive on Nov 15, 1958 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James W.C. Finney, M.D.				ADDRESS (Street, city or town, state) 3308 Union Ave, Harford, Md.			
PHYSICIAN'S NAME (Type) James W.C. Finney, M.D.				DATE SIGNED Nov 16, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 18 1958		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL		22d. LOCATION (City, town, or county) (State) HARFORD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Ward, Harford, Md. ADDRESS Harford, Md.				24a. REC'D BY REGISTRAR NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Kane	

TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 2 should be filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

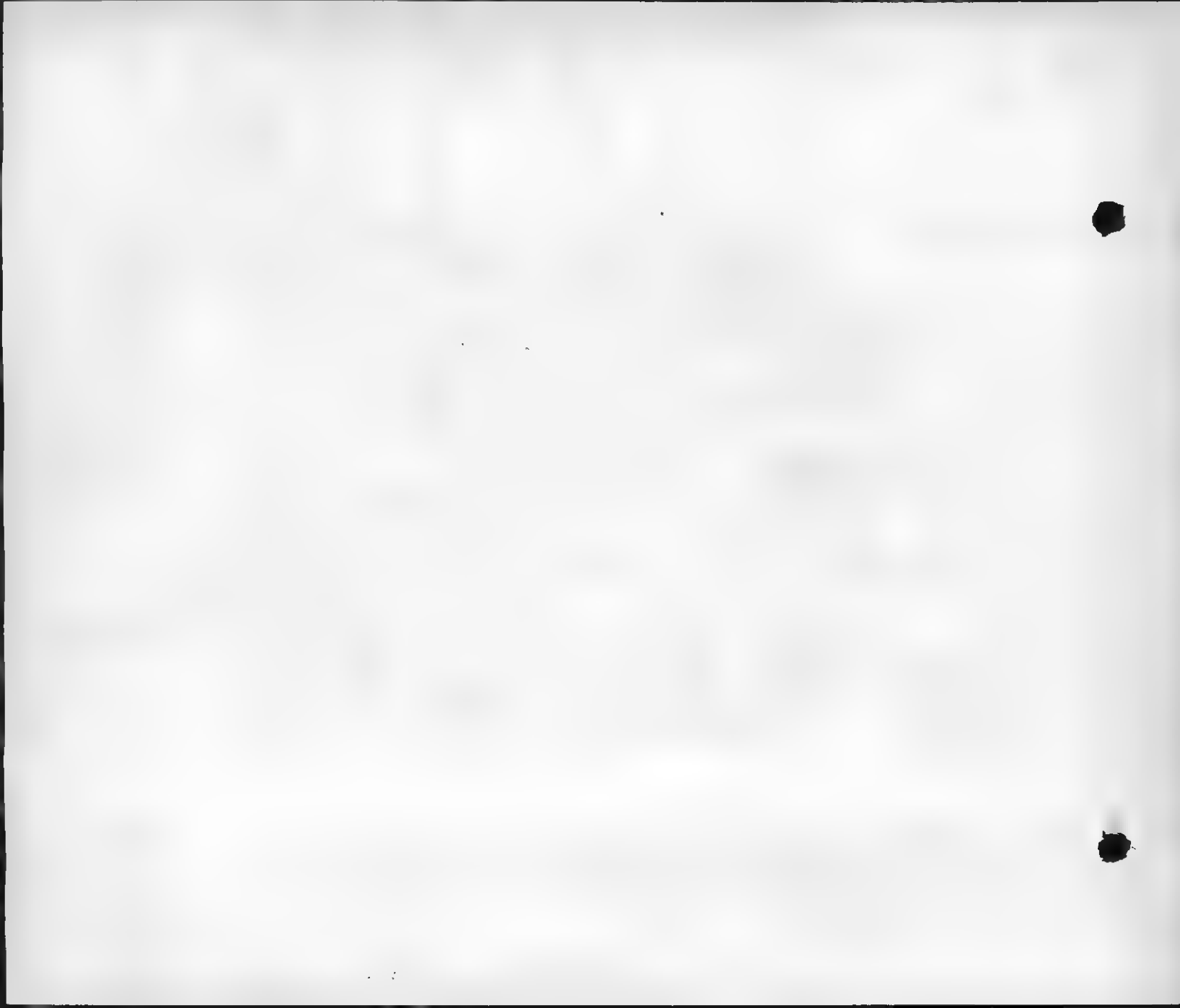
12563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hayford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Hayford</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Perryman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hayford Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Henry Warfield Jr.</u>		4. DATE OF DEATH <u>November 3 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21 1914</u>
9. AGE (In years last birthday) <u>44</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Proving Ground</u>	
11. BIRTHPLACE (State or foreign country) <u>Perryman, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Warfield Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Susie A. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>218-05-7976</u>	
17. INFORMANT <u>Mrs Katie M. Warfield</u>		Address <u>Perryman Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>REDAIR W</u> DATE SIGNED <u>11-9-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		24a. REC'D BY REGISTRAR <u>Havre de Grace</u> DATE <u>NOV 6 '58</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

12551

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet Place</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Clayton Road</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Lee Watson</u>		4. DATE OF DEATH <u>November 1 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 July 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL INDUSTRY</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Connie Yarbrough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES 1924-1925</u>		16. SOCIAL SECURITY NO. <u>216-10-3154</u>	
17. INFORMANT <u>MYRTLE WATSON</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis & V disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <u>11-2-58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL GARDEN</u>	22d. LOCATION (City, town, or county) (State) <u>BELAIR, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley</u>		24a. REC'D BY REGISTRAR <u>Neundach 22, Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kuntz</u>

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12565

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Haryord</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Haryord</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>60 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>23 Lee St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>23 Lee St</u>	
3. NAME OF DECEASED (Type or print) <u>John Watters</u>		4. DATE OF DEATH <u>November 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>	
11. BIRTHPLACE (State or foreign country) <u>Mountain View Md</u>		12. CITIZEN OF WHAT COUNTRY <u>MJ</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-20-0332</u>	
17. INFORMANT <u>MRS Mary E Witherspoon</u>		Address <u>23 Lee St Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO (a), stating the underlying cause lost. (c) <u>420.1</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>11-13-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 17-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shelburne Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>BELSON HARYORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u>		ADDRESS <u>Bel Air Md</u>	
24a. REC'D BY REGISTRAR <u>DAW 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Delaware</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toppa</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NS Route 40</u>		d. STREET ADDRESS <u>517 Mary St.,</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert</u> First Middle Last	<u>White</u>	4. DATE OF DEATH <u>November 26 1958</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Aug. 31, 1925</u>	9. AGE (In years last birthday) <u>33</u> ym.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Work</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Claude White</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Augusta Waller, 115 Youngs Ave, Woodlyn, Pa.,</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-26-58</u> Hour <u>11</u> a.m. <u>11</u> p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NS Route 40</u>	20f. (City or town) <u>Toppa</u> (County) <u>Hartford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11-27-58 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Delair, MD</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Nov. 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laws Funeral Home</u>	22d. LOCATION (City, town, or county) <u>Chester, Delaware, Penna.,</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McEwen Jr</u> ADDRESS <u>Abingdon, Maryland.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR NAME
HOMERID WEST

12303

RECORDS STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Deceased

Age Mary 82.

Mar. 31, 1925

U.S.A.

Virginia

House Work

Laborer

Mary Carter

Clara White

Augusta Waller, 115 Youngs Ave, Brooklyn, N.Y.

Chester, Delaware, Tenn.

Removal Nov. 27, 1926 Laws Funeral Home

Baltimore, Maryland.